# Medication Reconciliation Activity

Let the fun begin!!

# Be the Surveyor!

- Compare the medication orders, the MAR and the Medications.
- How many medication discrepancies can you find?
- Write down each discrepancy
- Some errors can be identified that are not directly related to the Medication Reconciliation Process, but are violations of rules--Remember, think as if you were a surveyor!
- The winning team gets a prize!!!

#### Problems Identified

- Lisinopril:
- 1) Order is for two 5mg tabs each AM and MAR reads one tab each AM
- 2) Medication Label is the correct dose, but the incorrect strength of tab

## Identified Problems Cont...

- Lasix:
- 3) Order reads ½ of 40 mg tab, MAR reads, one 40 mg tab

### Identified Problems....

- Glucophage:
- 4) Order reads ER Tab and Label states 500mg tab
- 5) Order reads to take tab with evening meal and MAR has medication scheduled for Noon

## Identified Problems....

- Fosamax:
- 6) MAR documents incorrect order. Current order is for Fosamax 35 mg weekly.
- 7) MAR does not provide instructions to staff
- \*Additionally, if the resident eats breakfast at 8 AM, medication would need to be scheduled to an earlier time.
- 8) Both the 35 mg and 5 mg tab are available.

## Identified Problems Cont...

- K-Dur
- 9) MAR should document for one tab to be taken twice daily, not once daily
- 10) Medication label reads two tabs once daily, not one tab, twice daily

## Identified Problems Cont...

Colace

11) Medication Label is for Pericolace.

## More Problems...

Norco:

12) Order is for PRN and MAR documents medication as scheduled

## Problems, Problems, Problems

- Bactrim:
- 13) Medication was ordered on 1/29/07 for 14 days and it is documented on the MAR the resident is still taking it as of 2/25/08
- 14) Medication is written on the MAR as once daily not twice daily

# ISSUES, ISSUES, ISSUES

Omeprazole:

15) Is not documented on the MAR



## Further Issues....

Celexa:

16) Order for Celexa is transcribed on the MAR as Celebrex

# Bigger Problems...

- Coumadin:
- 17): Coumadin was not stopped after hospital visit, when it was ordered that Primary Care Physician needed to be notified regarding resuming medication
- 18) Coumadin was not documented as given on M, W, F as ordered
- 19) Coumadin Medication Label was not changed to accurately reflect the new M, W, F order.
- 20) Coumadin was given on the 26<sup>th</sup>, when it should have been discontinued on that day.

## It continues...

#### Tylenol:

- 21) Tylenol present but no current order for it
- 22) Tylenol is in a bulk container
- 23) Tylenol is expired

### Misc..Problems...

- 24) No documentation on MAR of why medications were not taken
- 25) Nurse did not follow up on low BP's and provide further instruction to staff. Nurse did not give clear parameters on what BP's to report. (Resident missed 10 doses of BP med)
- 26) Aspercream must have an MD order and be monitored for correct usage
- 27) No standing orders.
- 28) Standing Orders were also expired

#### What Did You Think?

- Which medication had no issues?
- Who identified the most errors?
- How might the Medication Reconciliation process be a useful practice for the facility to utilize on a regular basis?
- Comments?

